Department of Health Care Services
Proposed May Revision Trailer Bill Language

Dissolve the California Medical Assistance Commission (CMAC) and Clarify Implementation Date of the Diagnosis Related Group (DRG) Methodology

Amend Welfare and Institutions Code section 14165 as follows:

14165. (a) There is hereby created in the Governor's Office the California Medical Assistance Commission, for the purpose of contracting with health care delivery systems for provision of health care services to recipients under the California Medical Assistance program.

(b) Notwithstanding any other provision of law, the commission created pursuant to subdivision (a) shall continue through December 31, 2011, after which, it shall be dissolved and the term of any commissioner serving at that time shall end.

(c) Upon dissolution of the commission, all powers, duties and responsibilities of the commission created in this code shall be transferred to the Secretary of the California Health and Human Services Agency, or his or her designee. These powers, duties and responsibilities shall include, but are not limited to, those exercised in the operation of the Selective Provider Contracting program pursuant to Article 2.6 of this chapter.

(d) On or before January 1, 2012, the position described in Section 14165.5 and all other staff positions serving the commission shall be transferred to the California Health and Human Services Agency.

(e)(1) Upon a determination by the Secretary that a payment system based on diagnosis-related groups as described in Section 14105.28 that is sufficient to replace the contract-based payment system referenced in subdivision (a) has been developed and implemented, the powers, duties and responsibilities conferred on the commission and transferred to the Secretary shall no longer be exercised.

(2) Upon the determination by the Secretary made pursuant to paragraph (1), the staff positions referenced in subdivision (d) shall be transferred to the department.

(f) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, or any other provision of law, the Secretary or the department may implement and administer this section by means of provider bulletins or other similar instructions, without taking regulatory action. Such authority to implement this section shall include the authority to give notice by provider bulletin or other similar instruction of the determination made pursuant to subdivision (d) and to modify or supersede existing regulations in title 22 of the California Code of Regulations that conflict with implementation of this section.

(g) Protections afforded to the negotiations and contracts of the commission under the provisions of the California Public Records Act (Government Code section 6250 et sequitur) shall be applicable to the negotiations and contracts of the California Health and Human Services Agency conducted or entered into pursuant to this section.

Amend Welfare and Institutions Code section 14105.28 as follows:

14105.28. (a) It is the intent of the Legislature to design a new Medi-Cal inpatient hospital reimbursement methodology based on diagnosis-related groups that more effectively ensures all of the following:

(1) Encouragement of access by setting higher payments for patients with more serious conditions.

(2) Rewards for efficiency by allowing hospitals to retain savings from decreased length of stays and decreased cost per day.

(3) Improvement of transparency and understanding by defining the "product" of a hospital in a way that is understandable to both clinical and financial managers.

(4) Improvement of fairness so that different hospitals receive similar payment for similar care and payments to hospitals are adjusted for significant cost factors that are outside the hospital's control.

(5) Encouragement of administrative efficiency and minimizing administrative burdens on hospitals and the Medi-Cal program.

(6) That payments depend on data that has high consistency and credibility.

(7) Simplification of the process for determining and making payments to the hospitals.

(8) Facilitation of improvement of quality and outcomes.

(9) Facilitation of implementation of state and federal provisions related to hospital acquired conditions.

(10) Support of provider compliance with all applicable state and federal requirements.

(b) (1) (A) (i) The department shall develop and implement a payment methodology based on diagnosis-related groups, subject to federal approval, that reflects the costs and staffing levels associated with quality of care for patients in all general acute care hospitals in state and out of state, including Medicare critical access hospitals, but excluding public hospitals, psychiatric hospitals, and rehabilitation hospitals, which include alcohol and drug rehabilitation hospitals.

(ii) ~~This section shall be implemented on the date that the replacement Medicaid Management Information System, described in subparagraph (C), becomes fully operational, but no later than June 30, 2014. The director shall execute a declaration stating the date on which the replacement system has become fully operational.~~ <u>The payment methodology developed pursuant to this section shall be implemented on July 1, 2012, or on the date upon which the Director executes a declaration certifying that all necessary federal approvals have been obtained and such methodology is sufficient for formal implementation, whichever is later.</u>

(B) The diagnosis-related group-based payments shall apply to all claims, except claims for psychiatric inpatient days, rehabilitation inpatient days, managed care inpatient days, and swing bed stays for long-term care services, provided, however, that psychiatric and rehabilitation inpatient days shall be excluded regardless of whether the stay was in a distinct-part unit. The department may exclude or include other claims and services as may be determined during the development of the payment methodology.

(C) Implementation of the new payment methodology shall be coordinated with the development and implementation of the replacement Medicaid Management Information System pursuant to the contract entered into pursuant to Section 14104.3, effective on May 3, 2010.

(2) The department shall evaluate alternative diagnosis-related group algorithms for the new Medi-Cal reimbursement system for the hospitals to which paragraph (1)

applies. The evaluation shall include, but not be limited to, consideration of all of the following factors:

(A) The basis for determining diagnosis-related group base price, and whether different base prices should be used taking into account factors such as geographic location, hospital size, teaching status, the local hospital wage area index, and any other variables that may be relevant.

(B) Classification of patients based on appropriate acuity classification systems.

(C) Hospital case mix factors.

(D) Geographic or regional differences in the cost of operating facilities and providing care.

(E) Payment models based on diagnosis-related groups used in other states.

(F) Frequency of grouper updates for the diagnosis-related groups.

(G) The extent to which the particular grouping algorithm for the diagnosis-related groups accommodates ICD-10 diagnosis and procedure codes, and applicable requirements of the federal Health Insurance Portability and Accountability Act of 1996.

(H) The basis for calculating relative weights for the various diagnosis-related groups.

(I) Whether policy adjusters should be used, for which care categories they should be used, and the frequency of updates to the policy adjusters.

(J) The extent to which the payment system is budget neutral and can be expected to result in state budget savings in future years.

(K) Other factors that may be relevant to determining payments, including, but not limited to, add-on payments, outlier payments, capital payments, payments for medical education, payments in the case of early transfers of patients, and payments based on performance and quality of care.

(c) The department shall submit to the Legislature a status report on the implementation of this section on April 1, 2011, April 1, 2012, April 1, 2013, and April 1, 2014.

(d) The alternatives for a new system described in paragraph (2) of subdivision (b) shall be developed in consultation with recognized experts with experience in hospital reimbursement, economists, the federal Centers for Medicare and Medicaid Services, and other interested parties.

(e) In implementing this section, the department may contract, as necessary, on a bid or nonbid basis, for professional consulting services from nationally recognized higher education and research institutions, or other qualified individuals and entities not associated with a particular hospital or hospital group, with demonstrated expertise in hospital reimbursement systems. The rate setting system described in subdivision (b) shall be developed with all possible expediency. This subdivision establishes an accelerated process for issuing contracts pursuant to this section and contracts entered into pursuant to this subdivision shall be exempt from the requirements of Chapter 1 (commencing with Section 10100) and Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(f) (1) The department may adopt emergency regulations to implement the provisions of this section in accordance with rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The initial adoption of emergency regulations and one readoption of the initial regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health, and safety or general welfare. Initial emergency regulations and the one readoption of those regulations shall

be exempt from review by the Office of Administrative Law. The initial emergency regulations and the one readoption of those regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and publication in the California Code of Regulations.

(2) As an alternative to paragraph (1), and notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, or any other provision of law, the department may implement and administer this section by means of provider bulletins, all-county letters, manuals, or other similar instructions, without taking regulatory action. The department shall notify the fiscal and appropriate policy committees of the Legislature of its intent to issue a provider bulletin, all-county letter, manual, or other similar instruction, at least five days prior to issuance. In addition, the department shall provide a copy of any provider bulletin, all-county letter, manual, or other similar instruction issued under this paragraph to the fiscal and appropriate policy committees of the Legislature.